DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

APR 3 1998

1. TRANSMITTAL NUMBER: 98 0 2

2. STATE: Alaska

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

FILE COPY

4. PROPOSED EFFECTIVE DATE
January 1, 1998

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250-447.252 and CFR 447.256-447.272

7. FEDERAL BUDGET IMPACT:
a. FFY 98 $ -0-
b. FFY 99 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D ~~pages 1-11~~ (P&I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D

10. SUBJECT OF AMENDMENT:
Optional payment rate methodology for small facilities for long term care facilities

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:
Does not wish to comment

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Bob Labbe

14. TITLE:
Director, Division of Medical Assistance

15. DATE SUBMITTED:
March 31, 1998

16. RETURN TO:
Division of Medical Assistance
P.O. Box 110660
Juneau, Alaska 99811-0660

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: APR 3 1998

18. DATE APPROVED: MAY 15 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JAN 1 1998

20. SIGNATURE OF REGIONAL OFFICIAL:
/S/

21. TYPED NAME:
Teresa M TRIMBLE

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR
DIVISION OF MEDICAID AND STATE OPERATIONS

23. REMARKS:

*POSTMARKED: 3/31 (DATE) * Juneau (CITY/STATE)

P&I changes are authorized by State on 5/7/01.

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN FOR MEDICAID PROVIDER REIMBURSEMENT

Long-term Care including Intermediate Care Facilities for the Mentally Retarded

Long-term care services and intermediate care services for the mentally retarded are paid for Medicaid recipients by means of rates determined in accordance with the following principles, methods and standards which comply with 42 CFR 447.250 through 477.272. ~~Assurances, findings and related information required by 42 CFR 447.253 and 447.255 have been transmitted separately and are not included in the description of the following payment methodology.~~ "P & I"

I. Introduction:

Rate setting principles and methods are contained in Alaska Statutes 47.07.070 - 47.07.900 and administrative regulations in Alaska Administrative Code 7 AAC 43.

Data sources used by Medicaid Rate Advisory Commission (Commission) and the Department of Health and Social Services (Department) are the following:

1. Medicare Cost Reports for the facility's fiscal year ending 24 months before the beginning of the facility's prospective rate year.

2. Budgeted capital costs, submitted by the facility and reviewed and adjusted by the Department as appropriate in accordance with Section II, for the rate year on capital projects or acquisitions which are placed in service after the beginning of the base year and before the end of the rate year and for which an approved CON (Certificate of Need) has been obtained.

   A CON is required for certain expenditures of $1,000,000 or more. Some situations requiring a CON include major alterations or additions to buildings, any addition or elimination of a major type of care in or through a facility, and any change in licensed beds within a two year period amounting to 10 beds or 10 percent of total beds.

3. Operating budgets, as applicable, submitted by new Medicaid providers.

4. Historical financial and statistical information submitted by facilities for past rate setting years.

5. Utilization and payment history provided by the Division of Medical Assistance.

II. Allowable Costs:

Allowable costs are documented costs that are ordinary and necessary in the delivery of a cost effective service. Allowable costs are those which directly relate to Title XIX program recipients. They are costs which must be incurred by an efficiently and economically operated provider. Costs would include those necessary to conform with the state and federal laws, regulations, and quality and safety standards.

Most of the elements of Medicaid allowable costs are defined in Medicare and reported, subject to audit, on the Medicare Cost Report. The following items are possible adjustments from financial statement classifications to Medicaid classifications, and may be reflected either within the Medicare Cost Report or elsewhere in the Medicaid cost finding process.

* return on investment is not an allowable cost for any facility.

* advertising cost is allowable only to the extent that the advertising is directly related to patient care. The reasonable cost of only the following types of advertising and marketing is allowable:

  - announcing the opening of or change of name of a facility.
  - recruiting for personnel.
  - advertising for the procurement or sale of items.
  - obtaining bids for construction or renovation.
  - advertising for a bond issue.
  - informational listing of the provider in a telephone directory.
  - listing a facility's hours of operation.
  - advertising specifically required as part of a facility's accreditation process.

* nursing staff in a long-term care facility is allowable as a routine cost only.

* physician compensation costs and charges associated with providing care to patients are not included as an allowable cost.

* medical services which a facility is not licensed to provide are not included as an allowable cost.

* costs not authorized by a certificate of need when a certificate of need is required are not included as allowable costs.

* pharmaceutical supplies and materials paid under other programs are not included as an allowable cost.

* management fees or home office costs which are not reasonably attributable to the management of a facility are not included as allowable costs.

"P & I"

Allowable patient related costs include wages, salaries, and employee benefits, purchased services, supplies, utilities, depreciation, rentals, leases, taxes, excluding local, state and federal income taxes, interest expense. A facility must reduce operating costs by the cost of all activities not directly related to health care. Other specific non-allowed costs are bad debts, charity, contractual adjustments and discounts taken by payers.

A Certificate of Need is required for certain expenditures of $1,000,000 or more. Situations requiring a CON include major alterations or additions to buildings, any addition or elimination of a major type of care in or through a facility, and any change in licensed beds within a two year period amounting to 10 beds or 10 percent of total beds. If a certificate of need is required on assets purchased after July 1, 1990, the amount of capital costs included in the rate calculation will be limited to the amounts described within the certificate of need application and other information the facility provided as a basis for approval of the certificate. In determining whether capital costs exceed those amounts approved under a certificate of need, and for determining the maximum prospective per diem rate approved under a certificate of need, the Department will consider:

(1) the terms of issuance describing the nature and extent of the activities authorized by the certificate; and

(2) the facts and assertions presented by the facility within the application and certificate of need review record, including purchase or contract prices, the rate of interest identified or assumed for any borrowed capital, lease costs, donations, developmental costs, staffing and administration costs, and other information the facility provided as a basis for approval of the certificate of need.

III. Inflation Adjustments:

Allowable costs are determined by adjusting base year data. Base year data will be the allowable operating costs excluding capital costs in the facility's fiscal year ending 24 months before the prospective rate year. For example, facilities whose fiscal year began July 1, 1997, the most current or fiscal year would be the fiscal year beginning July 1, 1994. The allowable base year costs are adjusted for inflation. Inflation is calculated annually using projected inflation indices developed based on data available in May prior to the facility's fiscal year beginning.

Substantial amounts of different economic and inflationary data sources are utilized to arrive at the most accurate Alaska inflationary factor possible. National inflation projections and economic trends such as those published by Data Resources, Incorporated and ACCRA (cost of living index) are utilized. Regional inflationary data that the Department has available is given consideration during the evaluation of inflation rates to be set. In addition to the published economic and inflationary reports considered in the analysis, the Department also considers recommendations of the Medicaid Rate Advisory Commission in the development of the inflation factors. Inflation is projected on a compound rate over a three year period of time. Inflation forecasts are developed based on anticipated changes in inflation using a HCFA type market basket.

The inflation factors applied to the long-term care services are as follows:

The three year average compounded inflation rate will be 7.2%.

Inflation rates for the following years will be used:

1996	2.1%
1997	2.4%
1998	2.5%

Compounding of inflation factors create a situation where the total is greater than the three years inflation factors. The adjustment then allows the inflation factors to be used independently. This results in allowable increases of costs attributed to inflation between 1996 and 1998 of 7.2%.

IV. Determination of Payment Rates:

The prospective payment rate for long-term care facilities is a single per diem rate with identified base capital and acquisitions which are placed in service after the beginning of the base year and before the end of the rate year and for which an approved CON has been obtained, routine and ancillary components. Ancillary costs include physician ordered patient specific billable services such as medical supplies charged to patients, respiratory therapy, physical and occupational therapy. Allowable costs are necessary and ordinary operating expenses including capital and insurance costs.

The base year operating expenses less base year capital are inflated by the indices described in Section III. Principal payments on debt are not included in capital costs. Base year capital is tested for reasonableness by comparing projected changes in capital expenditures and calculated using the greater of actual patient days or 85 percent of available licensed capacity days.

BASE YEAR

These methods and standards are revised to provide for a rebasing of costs incorporated into the rate calculation process for facilities with prospective fiscal years beginning January 1, 1997 through December

1, 1997. Base year and approved year financial and statistical information will be identical in rate calculations for facilities with fiscal years beginning during that time.

The reasonableness test is applied to not allow the rolling base year to unduly reward or penalize the providers. For example, the allowable costs per patient day (base) are subjected to a test of reasonableness where the 1994 base plus inflation is compared to the 1996 approved rate. For providers who maintain costs at a level less than the base plus inflation, the provider will be allowed to retain 50% of the savings up to 5% of the base. For the providers who have not maintained costs within the approved 1996 rate when inflation is added to the base, the provider will be able to keep only 50% of the difference not to exceed 5% of the base.

Allowable costs for routine services per day less capital as calculated in the base year are adjusted to reflect inflation between 1994 and 1996. This cost per day is compared to the approved cost per day in the 1996 year. The following adjustments are made:

1. If the base year costs exceed the approved costs, the allowable costs for 1997 will be limited to the 1996 approved costs plus the inflation between 1996 and 1997 plus 50% of the difference between the allowable costs of the two years limited to 5% of the costs in the 1994 base year.

2. If the base year costs are less than the approved costs, the routine service costs will be calculated using the 1994 allowable base costs plus inflation identified in the inflation section plus 50% of the difference between the two years limited to 5% of the costs in the 1994 base year.

Ancillary costs are built into the single calculated per diem rate. Actual ancillary costs are calculated from the 1994 base year costs less long-term care prescription drug costs. The costs are separated between base year capital and noncapital allowable costs. Inflation is added to the non-capital costs.

Ancillary and routine capital costs in the rate year are allowable facility base year capital costs, plus Department determined capital costs on CON approved capital additions which are placed in service after the beginning of the base year and before the end of the rate year.

A 1997 example of the calculation of allowable routine costs for a January 1 facility is as follows:

		1994 BASE	1996 APPROVED
Operating Expenses		$2,707,182	$2,861,358
Inflation on Base Year 1994-1996		124,503	
Total		$2,831,685	$2,861,358
Units of Measure		13,803	13,949
Rate per patient day		$205.15	$205.15
Total		$205.15	$205.15
Difference (Base-Current) (0.00)			
50% of Difference	0.00		
5% of Base	$9.81		
If Difference is Negative:			
Add 6.6% Inflation to Base		12.95	
Plus 50% or 5% whichever is less		0.00	
If Difference is Positive:			
Add 1.90% Inflation to Approved			
Plus 50% or 5% whichever is less			
1997 Allowable Routine Rate Per Patient Day		$209.08	

For FY 1997 each facility will be rolling off of their base year of 1994. For fiscal years after 1997 this calculation will be utilized to determine if the base year allowable routine rate will be based on the approved or the base year actuals. The determination process is outlined in **BASE YEAR** explanation.

The example for routine costs outlines the rate process where the 1994 base year costs equal the 1996 approved costs. The 4.6% inflation factor represents the Commission approved inflation between 1994 and 1996 for January 1 facilities. The 4.6% inflation is added to the 1994 routine costs per patient day for comparison to the 1996 approved rate per patient day. (The rate is adjusted by 50% of the difference between the 1994 rate and the 1996 rate not to exceed 5% of the 1994 rate.) In the example shown, 5% of the base is greater than 50% of the difference. Therefore, the 5% factor is used.

Calculation of Actual Allowable Ancillary Costs Per Patient Day 1997 rate example:

LONG-TERM CARE

Base Expenses	$156,443
Inflation (6.60%)	10,325
Total Allowable Base Expenses for 1997	$166,768
$166,768 divided by 12,472 equals	$ 13.37

Ancillary costs are calculated by inflating the 1994 actual Medicaid ancillary allowable costs less base year capital per patient day by the inflation factor identified in Section III. This Medicaid ancillary cost is divided by the Medicaid patient days from the 1994 base year.

The actual allowable ancillary costs are related to Medicaid patients only. The base year actual allowable costs are arrived at by dividing the lower of cost or charges into the allowable costs and then multiplying by Medicaid ancillary revenue. Allowable ancillary costs are limited to allowable Medicaid ancillary charges, which are reported by the facilities on the Medicare Cost Report worksheet D. The worksheet D ties to the facilities working trial balance as the amount charged to their Medicaid patients.

For the entire period, the total allowable Medicaid costs in the base year are then divided by the base year Medicaid patient days. For rates established on or after July 1, 1990, the cost of prescription drugs is not included as an ancillary cost. Prescription drug costs and charges are removed from the calculation of actual allowable ancillary costs through information provided by the individual facility, or if not available from the individual facility, from a sample of information submitted from other facilities.

Capital acquisitions not subject to CON approval and obtained after the base year are not included in the budgeted portion of rate year capital costs.

For the calculation of rate year capital costs, projected capital costs for post base year CON approved additions are included in the rate year during the first 3 rate years of asset use if the CON addition is estimated to be placed in service during or before the rate year.
No projected costs are added to the rate year capital for post base year acquisitions not subject to a CON. No costs are allowed for additions pending CON approval or for capital for which a CON was required and not obtained.

Newly constructed facilities shall have the rate set for the first three years at the Alaska Medicaid swing bed rate in effect at the start of the facility's rate year less the average capital costs contained in the swing bed rate plus the appropriate inflation factor. Capital costs identified by the facility are added to the rate using the greater of the occupancy rate approved in the certificate of need or assuming an 80% occupancy rate.

If a facility is granted a Certificate of Need to construct additional beds, the overall facility base year occupancy statistics will be adjusted for the first three rate years during which the additional beds are available for occupancy to reflect 50 percent of the base year occupancy for the additional beds.

OPTIONAL PAYMENT RATE METHODOLOGY FOR SMALL FACILITIES

As provided in Section V of Attachment 4.19-A, facilities that received combined inpatient hospital, outpatient hospital, and long term care Medicaid payments, including disproportionate share adjustments, of no more than $2,750,000 during the facility's fiscal year that ended during the period July 1, 1995 to June 30, 1996 may make an election for Medicaid reimbursement based on the Optional Payment Rate Methodology for Small Facilities. This election also applies to a free-standing long term care facility that received Medicaid payments of no more than $2,750,000 during the facility's fiscal year that ended during the period July 1, 1995 to June 30, 1996. The election requires the facility to be reimbursed under this method from the beginning of the facility's fiscal year that begins during the period January 1, 1998 to December 31, 1998, until the last day of the facility's fiscal year that ends during the period July 1, 2001 to June 30, 2002 (the election period). This subsection of Section IV of Attachment 4.19-D describes the optional payment rate methodology for long term care.

The long term care prospective payment rate will be a per diem rate based on the facility's approved Medicaid long term care rate and the department's rate analysis for the facility's fiscal year that began during the period January 1, 1997 to December 31, 1997 (the rate base). The prospective payment rate is composed of separate capital and non-capital portions. The capital portion is the same as the per diem capital in the rate base. The non-capital portion is the facility's total allowable costs (approved long term care Medicaid rate) less the capital portion of the rate base. The noncapital portion is increased annually at the rate of three percent per year.

The long term care prospective payment rate may be adjusted in the fourth year. The adjustment will be determined by comparing the number of Medicaid paid days in the base period to the average number of Medicaid paid days during the first three rate years of the election period. For purposes of making this calculation, the department will annualize the number of Medicaid paid days in the third year based on the number of Medicaid paid days reported by the facility during the first nine months of the third year. For each whole percent decline that exceeds 20 percent of the Medicaid paid days during the base period, the capital and noncapital portions of the rate for the fourth year will be increased by one percent.

The department will allow an increase in the capital component of the prospective payment rate for new assets valued at $5,000,000 or more that the facility places in service during the election period and for which a Certificate of Need was obtained. The facility must submit a detailed capital budget that reflects the estimated allowable costs for the new assets in service during the prospective rate year.

Prospective payment rates determined for the small facility, for certain years, must include an appropriate year-end conformance adjustment in accordance with Section VI. The year-end conformance adjustment for a small facility with a fiscal that ends June 30 is calculated based on the fiscal years of the small facility that end on June30, 1996, June 30, 1997, and June 30, 1998; and applies to the rates for the fiscal years of the small facility that end on June30, 1999, June 30, 2000, and June 30, 2001, respectively. For a small facility with a fiscal year that ends December 31, the year-end conformance adjusted is calculated based on the fiscal years of the small facility that end on December 31, 1995, December 31, 1996, and December 31, 1997; and applies to the rates for the fiscal years of the small facility that end on December 31, 1998, December 31, 1999, and December 31, 2000, respectively. No year-end conformance will be calculated on base years whose rates were calculated under this subsection.

Facilities electing to be reimbursed under the Optional Payment Rate Methodology for Small Facilities shall use the administrative appeals process described in Section VIII if the facility disputes an action or decision of the department that relates to:

- the facility's eligibility to make this election:
- a violation of a term of the agreement between the department and the facility;
- a year end conformance adjustment calculation applied during the election period;
- a denial of a CON increase in the prospective payment rate made under this election.

V. Sale of Facilities:

For facilities acquired on or after October 1, 1985, the increase in the depreciable base is limited to one-half of the percentage increase since the date of the sellers acquisition, in the Dodge Construction Systems Costs Index for Nursing Homes, or, one-half of the percentage increase in the consumer price index for all urban consumers, whichever is less. All related operating costs including interest are limited to the allowable changes in asset base. No facilities were sold or acquired between 1982 and October 1, 1985 or subsequent to October 1, 1985.

In addition, the recapture of depreciation expense on disposition of assets that accommodate gains under the Medicaid program will be limited by the provisions of 42 CFR 447.253(d) of the Code. Payment for acquisition costs associated with buying and selling of the facility will be limited by the provisions of 42 CFR 447.253 (d) of the Code.

Example of Purchase Limitations

Historical Costs

Book Value		$5,000,000
Accumulated Depreciation		2,500,000
Net Book Value		$2,500,000
Annual Depreciation		$ 200,000
Long-term Debt		$1,000,000
Interest on Debt		$ 100,000
Allowable Costs		$ 300,000
Purchase Price		$8,000,000
Depreciation		$ 400,000
Long-term Debt		$6,000,000
Interest on Debt		$ 600,000
Operating Costs		$1,000,000
Change in CPI (Since original acquisition)	25%	
Dodge Index	35%	
Allowable change 25% divided by 2 =	12.5%	
New Depreciable Base		$5,600,000
Accumulated Depreciation		2,800,000
Net Value		$2,800,000
Depreciation		$ 224,000
Allowable Interest Based on 40% debt prior to purchase on net value at historical 10% rate ($2,800,000 X 40% X 10%)		$ 112,000
Allowable Costs		$ 336,000

Note: The example is simplified for presentation. Original investment was assumed to be made at one time. There are no loan costs or start up costs factored in the original purchase or subsequent purchase.

VI. Year End Conformance:

Facilities with fiscal years beginning January 1, 1997 through December 1, 1997 will not have a Year End Conformance applied.

For fiscal years beginning January 1, 1998 and later, year end conformance will be reviewed for each facility. Approved ancillary rates for the fiscal year ended 24 months before the beginning of the rate year will be compared to the actual ancillary cost per patient day for that period. An adjustment to the

prospective rate will be calculated as 90 percent of the difference between the approved ancillary rate and the actual ancillary cost per patient day. If actual total facility costs per day are less than two percent above or below the approved total rate (without year end conformance in the base year rate, if any) no adjustment will be made. A positive adjustment will be limited to the amount that actual total facility costs exceeded the overall approved total rate (without year end conformance in the base year rate, if any) in the base year, and a negative adjustment will be limited to the amount that the approved total rate (without year end conformance in the base year rate, if any) in the base year exceeded the actual total facility costs in the base year.

The Department will, in its discretion, waive all or part of the year end conformance if the facility provides justification that manifest injustice will result if year-end conformance is strictly applied, based upon consideration of the following factors:

- whether the facility has taken effective measures to control costs in response to the situation upon which the waiver request is based.

- whether the waiver request contradict a prior action of the Department as to an element of the facility's rate.

- whether the waiver would result in payment for only allowable cost of services authorized by the division of medical assistance under state or federal laws.

- whether the situation upon which the waiver request is based results from the provision of direct patient care or from prudent management actions improving the financial viability of the facility to provide patient care.

VII. Adjustment to Rates:

Rates for facilities are set by the Department with the advice of five Governor appointed Commissioners. The Commissioners represent the state of Alaska, the providers, a physician, a certified public accountant and a consumer. Facilities have the opportunity to provide additional information on significant changes that would impact the rates.

The Department, on its own or at the request of an applicant, in its discretion, will reconsider its actions within 30 days. There is nothing to preclude a facility from petitioning the Department at any time during its fiscal year for additional consideration.

Reconsiderations are warranted only in those cases where the proper application of the methods and standards described in Attachment 4.19-D is in question or is being challenged.

VIII. Provider Appeals:

If a party feels aggrieved as a result of the Department's rate setting decisions, the party may appeal and request reconsideration or an administrative hearing.

Administrative hearings are conducted by Governor appointed Hearing Officers. An administrative appeal must be filed within 30 days of the mailing of the decision of the Department.

The Hearing Officer would hear a case in accordance with administrative law in the state of Alaska. The Hearing Officer would prepare draft findings, conclusions and order for the Commissioner of the Department's review. The Commissioner of the Department would review the findings of the Hearing

Officer and may accept, reject, or modify the Hearing Officer's recommendations. If the party still feels aggrieved at this point, judicial review is available to contest actions of the Department and the rate set.

IX. Audit Function:

The Department has statutory authority to audit data relating to Medicaid prospective payment rates. Audit findings that would affect prospective payment rates are adopted by the Department and incorporated into future prospective rate calculations.

X. **Exceptional Relief to Rate Setting:**

If the rate setting methodology results in a permanent rate which does not allow reasonable access to quality patient care provided by an efficiently and economically managed facility, the facility may apply to the Deputy Commissioner of the Department for exceptional relief from the rate setting methodology.

This provision applies to situations where a facility is forced to close or dramatically reduce quality of care to its residents due to the inadequacy of its payment rate. To apply for exceptional relief, the facility's application should include:

1. the amount by which the facility estimates that the rate should be increased to allow reasonable access to quality patient care provided by an efficiently managed facility;

2. the reasons why and the need for exceptional relief requested, including any resolution by the facility's governing body to support the reasons offered, and why such a rate increase cannot be obtained through the existing rate setting process;

3. the description of management actions taken by the facility to respond to the situation on which the exceptional relief request is based;

4. the audited financial statement for the facility for the most recently completed facility fiscal year and financial data, including a statement of income and expenses and a statement of assets, liabilities, and equities and a monthly facility cash flow analysis for the fiscal year for which the exception is requested;

5. a detailed description of recent efforts by the facility to offset the deficiency by securing revenue sharing, charity or foundation contributions, or local community support;

6. an analysis of community needs for the service on which the exception request is based;

7. a detailed analysis of the options of the facility if the exception is denied;

8. a plan for future action to respond to the problem; and

9. any other information requested by the Deputy Commissioner to evaluate the request.

The Deputy Commissioner may request recommendations from the Commission on a facility's application for exceptional relief. The Deputy Commissioner may increase the rate, by all or part of the facility's request if the Deputy Commissioner finds by clear and convincing evidence that the rate established under Section IV. and Section VI. of Attachment 4.19-D does not allow for reasonable access to quality patient care provided by an efficiently and economically managed facility and that the granting of an exception is in the public interest. In determining whether the exception is in the public interest, the Deputy Commissioner may consider at least:

1. the necessity of the rate increase to allow reasonable access to quality patient care provided by an efficiently and economically managed facility, including any findings of the governing body of the facility to support the need;

2. the assessment of continued need for this facility's services in the community;

3. whether the facility has taken effective steps to respond to the crisis and has adopted effective management strategies to alleviate or avoid the future need for exceptional relief;

4. the recommendations, if any, from the Commission;

5. the availability of other resources available to the facility to respond to the crisis;

6. whether the relief should have been obtained under the existing rate methodology;

7. other factors relevant to assess reasonable access to quality patient care provided by an efficiently and economically managed facility.

The Deputy Commissioner may impose conditions on the receipt of exceptional relief including, but not limited to the following:

1. the facility sharing the cost of the rate exception granted;

2. the facility taking effective steps in the future to alleviate the need for future requests for exceptional relief;

3. the facility providing documentation as specified of the continued need for the exception; or

4. a maximum amount of exceptional relief to be granted to the facility under this section.

If the Deputy Commissioner finds by clear and convincing evidence that the rate established under the methodology does not allow for reasonable access to quality patient care provided by an efficiently and economically managed facility and that the granting of an exception is in the public interest, the Deputy Commissioner may, in his or her sole discretion increase the rate.

Amounts granted as exceptional relief shall not be included as part of the base on which future prospective rates are determined. Exceptional relief shall be effective prospectively from the date of the exceptional relief decision and for a period of time not to extend beyond the facility's rate setting year. A facility may apply for and be granted exceptional relief in the following year. A party aggrieved by a decision of the Deputy Commissioner concerning exceptional relief may request an administrative hearing to the Commissioner of the Department.

XI. Public Process

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.